EMPLOYEE RESOURCE SYSTEMS, INC.
BILLING STATEMENT

Patient Information

Patient Name: ______________________________ (ERS Client ID#: ____________)

ERS Client Company: ____

EAP Affiliate/Agency Payment Information

Check Payable to: ______________________________ FEIN/SS#: ______________

Check Mailing Address: ____

City: __________________________ State: __________ Zip: ______________

PLEASE NOTE: Unauthorized sessions will not be reimbursed. Bills must be submitted within 60 days of the last contact with the client.

Session Date	Fee
1	**$65.00**
2	
3	
4	
5	
6	
7	
8	

TOTAL $______________________

Clinician's Signature ______________________________ **Date** ______________

Submit bills to:

Employee Resource Systems, Inc.
29 E. Madison, Suite 1600
Chicago, IL 60602
Fax: (312) 780-6344

Direct questions to:

Patty Gudas (866) 377-5550 x 6322
pgudas@ers-usa.org

FOR ERS USE ONLY! PLEASE DO NOT WRITE BELOW THIS LINE!

ERS Case Manager______________________________ Referral#______________

Date received______________________ Date paid______________ Check# ____________

1/3/2006

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Chicago, IL 60602
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www.ers-usa.org